IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

September 3, 2008

Russell McCoy
Church Hill Downs
415 South Arthur
Pocatello, ID 83204

RE: Church Hill Downs, Provider #13G043

Dear Mr. McCoy:

This is to advise you of the findings of the Medicaid/Licensure survey of Church Hill Downs, which was conducted on August 28, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **September 16, 2008,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by September 16, 2008. If a request for informal dispute resolution is received after September 16, 2008, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

SHERRI CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

SC/mlw

Enclosures

DEVELOPMENTAL OPTIONS
PROMOTING FUNCTIONAL INDEPENDENCE THROUGH PERSON-CENTERED SERVICES

September 16, 2008

Ms. Nicole Wisenor, Supervisor
Non-Long Term Care
Department of Health and Welfare
Division of Medicaid
Bureau of Facility Standards
P. O. Box 83720
Boise, ID 83720-0036

Dear Ms. Wisenor:

Please find enclosed the completed *STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION* for Church Hill Downs Group Home from the survey completed August 28, 2008. On the Statement of Deficiencies / Plan of Correction, Form HCFA-2567, I have listed the necessary corrective actions.

I hope you find the Statement of Deficiencies / Plan of Correction acceptable. If there is any additional information you require or if you have any questions, please contact me at the address listed below.

Sincerely,

Russell C. McCoy, M.A. Ed.
Executive Director

Enclosures

RECEIVED
SEP 18 2008
FACILITY STANDARDS

Russell C. McCoy, Executive Director • rmccoy@ida.net
415 South Arthur • Pocatello, Idaho 83204 • Phone (208) 233-6833 • Fax (208) 233-6842 • doptions@ida.net • www.developmentaloptions.com

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G043	A. BUILDING _____ B. WING _____	08/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHURCH HILL DOWNS	1722 CHURCH HILL DOWNS POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey. The surveyors conducting the survey were: Sherri Case, LSW, QMRP, Team Leader Michael Case, LSW, QMRP Common abbreviations used in this report are: ADHD - Attention Deficit Hyperactive Disorder BMP - Behavior Management Program HRC - Human Rights Committee IPP - Individual Program Plan LPN - Licensed Practical Nurse QMRP - Qualified Mental Retardation Professional SIB - Self Injurious Behavior	W 000	RECEIVED SEP 18 2008 FACILITY STANDARDS	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure outside services met the needs for 2 of 3 individuals (Individuals #1 and #3) whose educational services were reviewed. This resulted in the outside services not being sufficiently coordinated. The findings include: 1. Individual #1's IPP, dated 9/25/07, documented a 12 year old female diagnosed with moderate mental retardation, autism, ADHD and Disruptive Behavior Disorder. Individual #1 attended public school Monday through Friday.	W 120	**W120 483.410(d)(3)** The Qualified Mental Retardation Professional met with Individual #1's school teacher on September 8, 2008 and will mail her the requested information. The Qualified Mental Retardation Professional met with Individual #5's school teacher on September 10, 2008 and provided him with updated pertinent information that will assist with her school day. To ensure this deficiency does not occur again, the Qualified Mental Retardation Professional will meet with any individual's school teachers prior to a new school year and provide him/her with the current behavior management program, individual program plan and programs. The Qualified Mental Retardation Professional will also	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director 09/16/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 120	Continued From page 1 Individual #1's BMP, undated, defined Self Injurious Behavior as "hitting her head/face, scratching head/face/arms/legs, and banging her head on an object." Included in the "Staff Response" section of the BMP was the use of a protective helmet. The BMP stated if Individual #1 was "seen hitting her head 1 time; staff must assist her with putting on her protective helmet. She does not have a choice; it must be put on her head after she hits her head 1 time." The BMP stated Individual #1 could not remove her helmet until she had been calm for 10 minutes. An observation was conducted at the school on 8/26/08 from 1:40 p.m. - 2:30 p.m. During the observation, Individual #1 was noted to be outside walking on the paved track surrounding the football field. She was holding the teacher's hand. Individual #1 was noted to hit the right side of her face no less then 7 times as she walked around the football field. At that time the teacher was asked if she had received information from the home regarding Individual #1's SIB. The teacher stated the home had not provided any information to her, but Individual #1's mother had told her to put the helmet on Individual #1 if she hit herself. When asked where the helmet was, the teacher stated she had not brought it outside. At approximately 2:10 p.m., Individual #1 began walking into the school building with the teacher and again was noted to hit the right side of her head no less than 5 times prior to reaching her classroom. Upon entering the classroom, Individual #1 sat in a chair and hit the teaching assistant. The teacher asked the assistant to locate the helmet and to put it on Individual #1. Individual #1 was noted to hit the assistant and another student. After placing the helmet on	W 120	provide the school with updates throughout the school year. Corrective Action Completion Date: October 27, 2008 Person Responsible: Jamie L. Anthony, Residential Program Director	

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W 120	Continued From page 2 Individual #1 the assistant asked a second assistant if the helmet was to be left on for 30 seconds or 1 minute. The first assistant then told Individual #1 the helmet would be removed when she had been calm for 1 minute. The first assistant removed the helmet at approximately 2:15 p.m. During interview, on 8/28/08 at 12:12 p.m., the QMRP stated she had not provided any information to Individual #1's teacher. The QMRP stated she had thought since Individual #1's BMP had not been revised since the previous year the school would transfer the information to Individual #1's new teacher. The facility failed to ensure the school was provided with Individual #1's BMP. 2. Individual #5 was an 18 year old female diagnosed with moderate mental retardation who attended public school Monday through Friday. An observation was conducted at the school on 8/26/08 from 11:10 - 11:40 a.m. At that time the teacher was interviewed and stated this was his first year teaching. He stated he had concerns regarding Individual #5's SIB and he was documenting the behavior, but the home had not requested the information from him. He also stated he had not received any information from the home regarding Individual #5's behavioral interventions or learning objectives. During interview, on 8/28/08 at 12:25 p.m., the QMRP stated she had not provided any information to Individual #5's teacher. The facility's failure to ensure Individual #5's BMP	W 120		

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W 120	Continued From page 3 or learning objectives were provided to the school.	W 120		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the human rights committee for 1 of 3 individuals (Individual #3) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals on restrictive interventions. The findings include: 1. Individual #3's IPP, dated 11/12/07, documented a 20 year old female diagnosed with severe mental retardation. Individual #3's dental record documented the use of a papoose board on two (2) dental examinations, dated 11/28/07 and 5/30/08. However, Individual #3's record did not contain evidence of HRC approval for the restrictive intervention. When asked, the LPN stated during an interview on 8/28/08 at 12:55 p.m., HRC approval had not been obtained. The facility failed to ensure the facility's HRC approved the use of a papoose board prior to	W 262	**W262 483.440(f)(3)(i)** The Qualified Mental Retardation Professional will obtain HRC approval for the use of a papoose board for Individual #3's dental visits. To ensure this deficiency does not occur again, the Lead LPN will review dental reports and report any use of a papoose board (not already noted) to the Qualified Mental Retardation Professional so that proper approvals can be obtained. Corrective Action Completion Date: October 27, 2008 Person Responsible: Jamie L. Anthony, Residential Program Director	

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W 262	Continued From page 4 Individual #3's dental examinations.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the parent/guardian for 1 of 3 individuals (Individual #3) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior approval of a restrictive intervention. The findings include: 1. Individual #3's IPP, dated 11/12/07, documented a 20 year old female diagnosed with severe mental retardation. Individual #3's dental record documented the use of a papoose board on two (2) dental examinations, dated 11/28/07 and 5/30/08. However, Individual #3's record did not contain evidence of guardian consent for the restrictive intervention. When asked, the LPN stated during an interview on 8/28/08 at 12:55 p.m., guardian approval had not been obtained. The facility failed to ensure guardian consent for Individual #3 was obtained prior to the use of the papoose board.	W 263	**W263 483.440(f)(3)(ii)** The Qualified Mental Retardation Professional will obtain guardian approval for the use of a papoose board for Individual #3's dental visits. To ensure this deficiency does not occur again, the Lead LPN will review dental reports and report any use of a papoose board (not already noted) to the Qualified Mental Retardation Professional so that proper approvals can be obtained. Corrective Action Completion Date: October 27, 2008 Person Responsible: Jamie L. Anthony, Residential Program Director	

Bureau of Facility Standards

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MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194	**MM194 16.03.11.075.10(a)** Please refer to W262	
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196	**MM196 16.03.11.075.10(c)** Please refer to W263 RECEIVED SEP 18 2008 FACILITY STANDARDS	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. The findings include: During an environmental survey conducted on 8/27/08 from 11:30 - 12:00 p.m., the following concerns were noted:	MM380	**MM380 16.03.11.120.03(a)** Cupboard – Unfinished areas will be refinished. Corrective Action Completion Date: October 1, 2008 Person Responsible: Sam Guyette, Physical Facilities Manager. Lazy Susan – Crumbs were cleaned and item was added to the weekly home inspection. Corrective Action Completion Date: September 5, 2008 Person Responsible: Jamie Anthony, Residential Program Director.	

Bureau of Facility Standards

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MM380	Continued From page 1 - The cupboard by the stove, the cabinet with the cookie sheets in it, and the cabinet with the toaster had unfinished wood. - There were food crumbs in the cabinet under the lazy Susan. - Four metal cookie sheets had baked on grease on them. - There was an 8 inch by 6 inch dark stain in front of the couch in the living room. - There was a 2 inch square hole in the carpet in front of the television. - There was a thick layer of dust on the exhaust vent in the shower bathroom.	MM380	Carpet – The carpet is scheduled for cleaning every 3 months. An additional cleaning will be scheduled. The item will also be added to the weekly home inspection. A hand-held carpet cleaner will be purchased for each home to remove stains as they occur. Corrective Action Completion Date: October 31, 2008 Person responsible: Jamie Anthony, Residential Program Director. Exhaust vent in shower room – The vent was cleaned on 09/07/08. Cleanliness of the vent will be added to the weekly home inspection. Corrective Action Completion Date: October 27, 2008 Person responsible: Jamie Anthony, Residential Program Director.	
MM859	16.03.11.270.08(f)(i) Supervision of Training and Habilitation Supervision of delivery of training and habilitation services integrating various aspects of the facility's program; and This Rule is not met as evidenced by: Refer to W120.	MM859	**MM859 16.03.11.270.08(f)(i)** Please refer to W120	